Report Card Stakeholder Issues and Refrains
June 2002

Who did we hear from?

Personal interviews with 12 stakeholders were held in late June. All of the interviewees were from Western Washington. Several had multiple roles, such as parent, employer and service organization leader. Using the primary role in which they were interviewed, the 12 represented the audiences as follows:

1 from service organizations
1 from United Way
2 from schools
2 from health field (but no physicians)
2 from DSHS
2 from business community (but only one employer)
1 from community networks
1 legislative staff

Two of the 12 were from Vancouver, two were from Everett and the rest were from the Olympia area. The twelve were sent a Wellness Fact Sheet and the draft Report Card prior to the interviews. Tables showing data on the indicators were presented during the interview if that was appropriate to the discussion at hand.

The interviews were relatively unstructured around three broad topics:

- What is currently working well to support health in their communities, what needs improvement, and what are the barriers to improving health?
- What is their reaction to the report card—does it make intuitive sense, is it clear, are there too many items, too few? Any comments regarding the indicators?
- How might the report card be used to improve health? What would it take for the report card to be useful and actually be used? What kinds of materials and tools need to be developed?

What did we hear?

The interviewees varied considerably with respect to their health related backgrounds and their roles. Some talked in detail about the specific indicators, some spoke more generally about health and their communities, and some focused on specific populations.

Two common refrains did emerge from the varied discussions.

- One refrain is the need for and importance of repetition with respect to the education message. People need to hear things over and over again from multiple

sources/media in order to "get it." One person noted that it will take a 10 to 15 year campaign.

- Another refrain is the need for clear accountability built into the report card if it is to be more than another piece of paper with data. Financial rewards and penalties are essential, such as tying local hospital administrator salaries to community health outcomes.

The information gleaned from the interviews is organized around 1) the structure and design of the report card; 2) the indicators; 3) materials and medium of messages; and, 4) what can be done.

1) Structure and design of the report card. People were interested in the CDC determinants of health and felt that it told a powerful story. Most were surprised at the relatively low contribution of the health care system to health. Most thought that the report card design should clearly portray the relative determinants of health, whether with a pie chart (visually) or with numbers (50%, 20%, 10%). Understanding the determinants and the proportions opens up thinking about health.

Most thought the number and types of indicators on the report card were about right, but one person thought there was too much detail on the "Supportive" side of the card. He thought there should be more balance between the left and the right, especially since behavior is the larger determinant of health. One person commented that we read from left to right and therefore behaviors, which are the larger determinants should be on the left rather than the right.

Some commented that the report card needs to designed as a marketing message and designed to highlight the key ideas. It needs better graphics, use of color and fonts.

2) Indicators. A couple of people wanted the health status indicators to be parallel. Years of health life is followed by "perceived" mental health. Why perceived? And "readiness to learn" is a non sequiter. "Early brain development" would be better.

The standards suggested by the indicators for nutrition and exercise are too high. The measures should gauge whether we are making progress toward better nutrition and sufficient exercise. Nutrition should reference breakfast eating.

"Unmet need" was not readily understood and needed explanation. Everyone thinks in terms of access—do you have it or don't you? Emergency room utilization would be a good health care system indicator.

Almost everyone who focused specifically on the indicators commented on "binge drinking" as an inadequate measure of drug and alcohol abuse. A couple of people talked about methamphetamine and labs given that it is a hot issue.

OSPI's measure of high school graduation rates is not very good. Encourage OSPI to get a better measure. (They are developing a student id number that would support a better measure).

It is important to measure the general degradation of water and the food chain from reproductive hormones in the water, antibiotics in meat and pesticides in food. Are we currently testing for those things?

3) Materials and medium for message. As noted above, almost everyone thought the determinants of health, including their relative strengths, should be highlighted in the report card and supporting materials. It was seen as the key message that was empowering and also suggested responsibility and accountability for one's health. "Citizens are responsible for their health!"

However, it was also thought that the message was important as a part of a larger drumbeat—that the message had to be heard from many sources, not just the health department, and that standing alone, the report card probably won't accomplish much.

People thought that it was important to show the relationships between and among variables, such as between health and success in school and school impact on health. Benchmarks should be developed around those interconnections. For example, explain that communities that support kids have high graduation rates and benchmark communities around that. This communicates that it is not just the responsibilities of the schools and parents, but that the broader community has some responsibility.

There is an opportunity with the tobacco settlement money to impact health through education around health issues. Cable TV is an important resource. Audiences can be specifically targeted relatively cheaply (men, women, older people, teens etc.).

Libraries are an important resource in disseminating this kind of information

The community information line, 211, is not completely designed as yet, and that might be a communications resource for health information/education.

Materials should tell stories that are real. Publicize success stories, especially local (Washington State) success stories. Specific steps that people can take need to be specified. Steps and strategies should be articulated for individuals, businesses, neighborhood associations, and county/city collaboratives.

Data should be disaggregated geographically. All politics are local, and successful interventions will only occur locally. Data should also be disaggregated for low income people. There is a huge difference between them and the more affluent folks where health is concerned

You need a "Who" to go with the "What" of the message. The who is preferably someone outside of the health field. Various names were mentioned by different

interviewees including the Governor, Bill Gates, Chairman of the Board for Boeing, and the U.S. President.

When communicating with physicians you have to tap into specialties—make it relevant to the specialty. E-mail is a good way to communicate, as well as specialty newsletters.

The Association of Washington Businesses publishes a monthly newsletter and a quarterly magazine that could be used to communicate success stories about wellness programs. It would be helpful to have better measurements/estimates of the benefits of wellness programs. Business is very clear about the cost aspects; it is less clear about the financial benefits. Credible, understandable estimates or methods for determining them would help businesses focus on benefits rather than just costs.

Policy makers often see their decisions as funding health (e.g., parks) or economic development. We have to show that health IS economic development (healthy community=healthy workforce=effective economic development).

4) What can be done? Several interventions were mentioned. For example, teaching young children proper hand washing led to fewer illnesses and missed school (daycare).

Schools can improve lunches nutritionally, put juice instead of soda in vending machines, support physical activities, and provide health education. However, others noted that schools needed to focus on reading, math and science. Also, there needed to be a balance between nutrition and what kids will eat. The money from vending machines is used for key educational activities, and vending machines will lose money if soda is not provided.

OSPI has continually delayed implementation of the healthy fitness assessment tool in its accountability system. It is now slated for 2010, and some think that it is unlikely to be implemented at that point. It has also now been combined with the arts and social studies assessment, further watering it down.

Various employee wellness plans were mentioned including Glaxco-Smith-Kline (which went through a merger and might not be doing it anymore), Hewlett Packard which is merging with Compaq. Boeing has a gym, but doesn't promote its usage. Snohomish County Government had a health incentive program earlier (HOP for health), but dropped it due to budget cuts.

Develop and implement a FAT tax similar to taxes on tobacco and alcohol, such as a penny per gram of fat. This could fund a lot of health education and health care programs, not to mention parks and safe places to walk.

A food pyramid on the refrigerator is a helpful reminder at the individual/family level.